



CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Name: _____ Date: ____/____/____
Last First M.I.

Address: _____
Street City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

E-mail _____ Age: _____

Soc. Sec. No.: _____ Birth Date: ____/____/____
MM/DD/YYYY

Spouse: _____ Referred By: _____
Last First M.I.

Patient's nearest relative: _____ Phone: _____

Male Female

Married Widowed

Single Divorced

Employment Information

Employer: _____ Occupation: _____

Address: _____ Phone: _____
Street City State Zip

Insurance Information

Insurance Company: _____ Auto Accident Workers Compensation

Please make sure we have a copy of your insurance card and all necessary insurance information.

Complaint Information

Purpose of this appointment (Major Complaint): _____ (Please indicate on pain drawing)

When did you first notice the pain/symptoms? _____

How often do you experience your symptoms? Constantly (76-100% of the time) Frequently (51-75% of the time)
 Occasionally (26-50% of the time) Intermittently (1-25% of the time)

How are your symptoms changing with time?
 Getting Worse Staying the Same Getting Better

How much has the problem interfered with your work?
 Not at all A little bit Moderately Quite a bit Extremely

How much has the problem interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

How do you think your problem began? _____

Do you consider your problem to be severe? Yes Yes, at times No

What activities aggravate your condition? _____

What concerns you the most about your problem; what does it prevent you from doing?

Have you lost any days from work? Yes No

Other doctors seen for this condition: MD/DO PT MT DC other: _____

Past History

Have you been treated for any health conditions by a physician in the last year? Yes No

Describe: _____

What medications, vitamins, or drugs are you taking? _____

What operations have you had? _____

Describe any serious illnesses: _____

Have you ever been under Chiropractic Care? Yes No Doctor's Name: _____

Review of Systems

Have you Ever Suffered From:

Now / Past	Condition	Please Describe	Now/Past	Condition	Please Describe
<input type="checkbox"/>	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	_____
<input type="checkbox"/>	<input type="checkbox"/> Allergies/Hay Fever	_____	<input type="checkbox"/>	<input type="checkbox"/> Prostate Trouble	_____
<input type="checkbox"/>	<input type="checkbox"/> Colds/Sinus Infection	_____	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	_____
<input type="checkbox"/>	<input type="checkbox"/> Difficulty Breathing	_____	<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease	_____
<input type="checkbox"/>	<input type="checkbox"/> Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/> Bruising Easily	_____
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/>	<input type="checkbox"/> Itching	_____
<input type="checkbox"/>	<input type="checkbox"/> Eye Pain/Failing Vision	_____	<input type="checkbox"/>	<input type="checkbox"/> Bursitis/Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/> Deafness/Ear Noises	_____	<input type="checkbox"/>	<input type="checkbox"/> Varicose Veins	_____
<input type="checkbox"/>	<input type="checkbox"/> Nosebleeds	_____	<input type="checkbox"/>	<input type="checkbox"/> Anemia/Fatigue	_____
<input type="checkbox"/>	<input type="checkbox"/> High/Low Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/> Swelling of Ankles/Joints	_____
<input type="checkbox"/>	<input type="checkbox"/> Rapid/Slow Hear Rate	_____	<input type="checkbox"/>	<input type="checkbox"/> Poor Circulation	_____
<input type="checkbox"/>	<input type="checkbox"/> Nervousness/Depression	_____	<input type="checkbox"/>	<input type="checkbox"/> Cramps or Backache	_____
<input type="checkbox"/>	<input type="checkbox"/> Kidney Infection or Stones	_____	<input type="checkbox"/>	<input type="checkbox"/> Irregular Cycle/Excessive Menstrual Flow	_____
<input type="checkbox"/>	<input type="checkbox"/> Indigestion/Nausea	_____	<input type="checkbox"/>	<input type="checkbox"/> Lumps in Breast	_____
<input type="checkbox"/>	<input type="checkbox"/> Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/> Hot Flashes	_____
<input type="checkbox"/>	<input type="checkbox"/> Colon Trouble/Diarrhea	_____	<input type="checkbox"/>	<input type="checkbox"/> Foot Trouble	_____

Activities of Daily Living

Habits:	Heavy	Moderate	Light	None	
Alcohol	_____	_____	_____	_____	
Coffee	_____	_____	_____	_____	
Tobacco	_____	_____	_____	_____	
Drugs	_____	_____	_____	_____	
Exercise	_____	_____	_____	_____	
Sleep	_____	_____	_____	_____	
Appetite	_____	_____	_____	_____	
What activities do you do at work?					
<input type="checkbox"/> Sit:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> Stand:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> Computer work:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> On the phone:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
Have you ever been hospitalized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, why:	_____				
What would you rate your overall health?		<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor
What type of exercise do you do?		<input type="checkbox"/> Strenuous	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	<input type="checkbox"/> None
Indicate if you have any immediate family members with any of the following:					
<input type="checkbox"/> Rheumatoid Arthritis		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Lupus	
<input type="checkbox"/> Heart Problems		<input type="checkbox"/> Cancer		<input type="checkbox"/> ALS	

PAYMENT IS EXPECTED AT TIME OF VISIT!

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any insurance claim forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Should no payment be received on my account for sixty days there will be a 1.5% or \$2.00 minimum service charge added to the account each month.

Patient's Signature: _____ Date: _____

Gaurdian or Spouse's Signature Authorizing Care: _____ Date: _____

Information Taken By: _____ Date: _____

Comments: _____



The
CHAN INSTITUTE
of Health and Wellness

Chan Chiropractic Clinic, P.S.

4339 West Kennewick Ave
Kennewick, WA 99336-2802

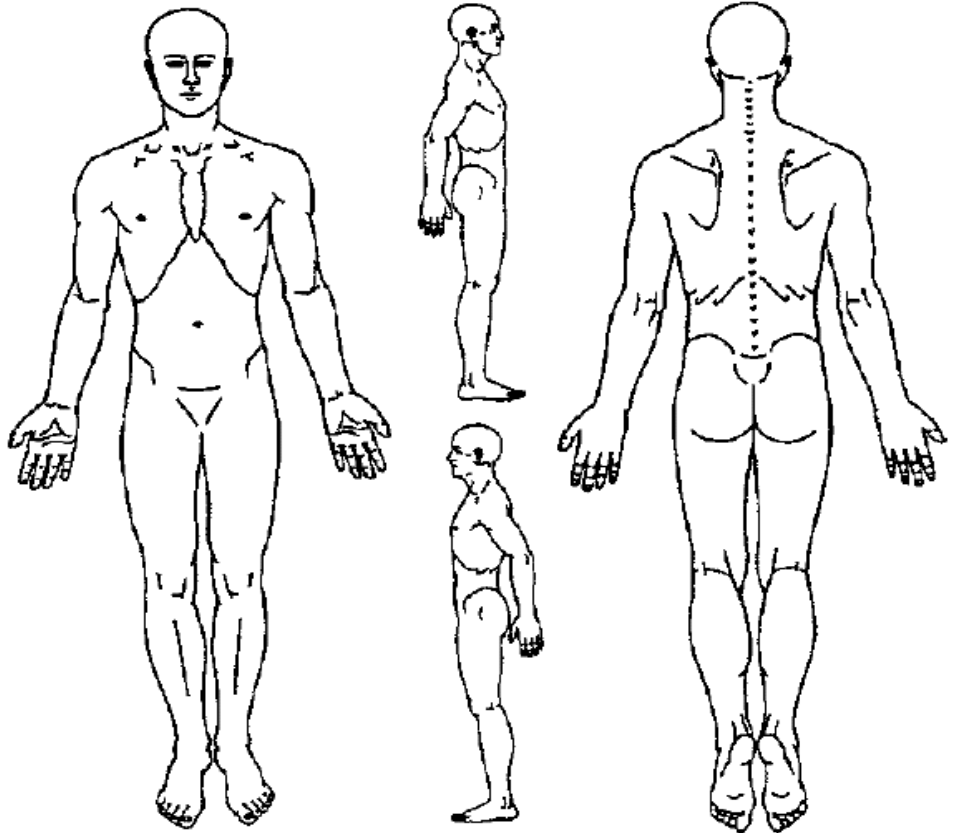
Pain Drawing Quadruple Index

Patient Name(Print) _____ Date _____

Patient ID# _____

Please circle the location of pain or discomfort on the images below. Use the letters shown to represent the type of pain:

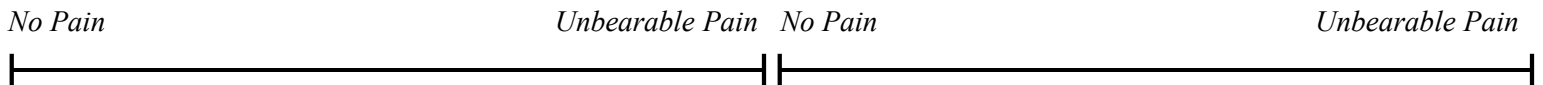
- D=Dull/Achy
- S=Stabbing/Cutting
- B=Burning
- T=Tingling
(Pins&Needles)
- N=Numb
- S=Shooting
- C=Cramping



On the scales below, please draw a vertical line representing your pain or discomfort.

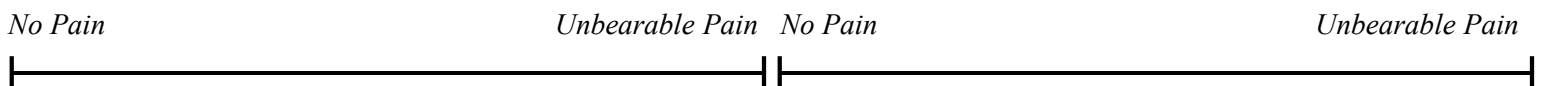
Rate the pain you have right **NOW**:

Rate your pain at its **BEST** in the past week:



Rate your **AVERAGE** pain in the past week:

Rate your **WORST** pain in the past week:





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509-735-0311

Fax: 509-783-1206

4339 West Kennewick Avenue

Kennewick, WA 99336-2802

Motor Vehicle Collision Questionnaire

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Location		
Date of Accident: _____	Time of Accident: _____	
Number of Vehicles: _____	Estimated Damages: _____	
State: _____	City: _____	Street: _____
Direction at time of impact: <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West		
Type of Impact: <input type="checkbox"/> front <input type="checkbox"/> drivers side <input type="checkbox"/> passenger side <input type="checkbox"/> rear end <input type="checkbox"/> other: _____		

Accident Information		
Where were you sitting during the accident?	<input type="checkbox"/> driver	<input type="checkbox"/> front passenger <input type="checkbox"/> right rear passenger
		<input type="checkbox"/> rear passenger <input type="checkbox"/> left rear passenger
Did you anticipate the impact?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Your vehicle type: _____	Other vehicles type: _____	
At the time of impact what was your vehicles speed? _____	Other vehicle speed? _____	
During and after the crash what happened to your vehicle? (Check all that apply)		
<input type="checkbox"/> kept going straight	<input type="checkbox"/> kept going straight hitting a car in front	<input type="checkbox"/> spun around
<input type="checkbox"/> hit stationary object	<input type="checkbox"/> spun around and hit a stationary object	<input type="checkbox"/> was hit by another vehicle
Did you loose consciousness during the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How was your head positioned during the accident?	_____	
How was your torso positioned during the accident?	_____	
How were your hands positioned during the accident?	_____	
Did any part of your body impact any part of the car?	<input type="checkbox"/> Head	<input type="checkbox"/> Face <input type="checkbox"/> Shoulders <input type="checkbox"/> Neck
	<input type="checkbox"/> Knees <input type="checkbox"/> Feet	<input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Chest <input type="checkbox"/> Hips
Please describe: _____		

Vehicle Information		
What kind of headrest does your vehicle have?	<input type="checkbox"/> moveable fixed	<input type="checkbox"/> nonmoveable fixed <input type="checkbox"/> none
What was the position of the headrest on your head?	<input type="checkbox"/> above	<input type="checkbox"/> below <input type="checkbox"/> in the middle
Was your seatbelt fastened?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you slide out of your seatbelt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What was damaged in your vehicle? (Check all that apply)		
<input type="checkbox"/> winshield	<input type="checkbox"/> rear bumper	<input type="checkbox"/> mirror <input type="checkbox"/> steering wheel <input type="checkbox"/> front bumper <input type="checkbox"/> kneebolster
<input type="checkbox"/> dashboard	<input type="checkbox"/> trunk	<input type="checkbox"/> back right door <input type="checkbox"/> seat frame <input type="checkbox"/> front left door <input type="checkbox"/> side window
	<input type="checkbox"/> rear window	<input type="checkbox"/> front right door <input type="checkbox"/> back left door <input type="checkbox"/> completely totaled
Choose the items that dented inward:	<input type="checkbox"/> floorboards	<input type="checkbox"/> side doors <input type="checkbox"/> dashboard <input type="checkbox"/> none
Were any of the car doors unable to open?	<input type="checkbox"/> Yes	<input type="checkbox"/> No Which: _____

Hospital Information		
Did you go to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How did you get to the hospital? _____
Name of hospital: _____	Duration: _____	
Were you prescribed any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____
Did you have any x rays taken while at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**The Chan Institute of Health and Wellness
4339 West Kennewick Avenue
Kennewick, Washington 99336-2802
509-735-0311**

Consent for Purposes of Treatment, Payment & Healthcare Operations (6/04)

In this document, “I” and “my” refer to the patient,
and “Institute” refers to The Chan Institute of Health and Wellness.

I consent to the use or disclosure of my protected health information by Institute for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Institute. I understand that analysis, diagnosis or treatment of me by Institute may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Institute is not required to agree to the restrictions that I may request. However, if Institute agrees to a restriction that I request, the restriction is binding on Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Institute has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Institute and understand that I have a right to a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Institute. The Notice of Privacy Practices for Institute is also posted in the waiting room at 4339 W. Kennewick Ave., Kennewick, WA 99336. This Notice of Privacy Practices also describes my rights and duties of the Institute with respect to my protected health information.

Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Institute and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

CHAN CHIROPRACTIC CLINIC, P.S.

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment.

FULL PAYMENT (DEDUCTIBLES AND CO-PAYS) IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

Regarding Insurance:

We may accept assignment of insurance benefits. However, we do require 50% of the bill to be paid at time of service unless arrangements are made with the doctor. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and/or an original claim form. **Your insurance policy is a contract between your insurance company and you.** We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you for payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurances.

Authorization Requirements:

When insurance companies require pre-authorization, we will apply on your behalf. However, your insurance company may refuse to authorize the treatment plan recommended by the doctor. You will be financially responsible for the non-authorized visits.

Arbitration Agreement:

Should any dispute as to malpractice arise, the case will be determined by submission to arbitration as provided by state and federal law. By signing this you are giving up your constitutional right to have such dispute decided in a court of law before a jury and are accepting the use of arbitration.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and/or customary rates.

Adult and Minor Patients:

Adult patients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or legal guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made for payment by cash or check at time of service.

Missed Appointments:

Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Third Party Payment:

In certain cases, a third party may be responsible for payment of your account. We may hold any outstanding bills and file a medical lien to secure the payment of this debt. The lien will be filed with the County Auditor's office and will remain on file until the account is settled or the claim is closed, at which time payment is due. A charge for processing the lien and administrative fees will be applied to your account balance.

I have read the Financial Policy. I understand and agree to this Financial Policy: I hereby assign payment of Insurance benefits to Chan Chiropractic Clinic, P.S.

X _____
Signature of Patient or Responsible Party

Date

X _____
Signature of Co-Responsible Party

Date

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date

ROLAND MORRIS DISABILITY INDEX

Name: _____ Date: _____ File #: _____
(please print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- I stay home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Form by Roland M. Morris R. Spine 1983; 8(2): 141-144. Lippincott-Raven Publishers

Score: _____

Improvement: _____ %

LOW BACK DISABILITY INDEX

Revised Owestry

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

SECTION 10 – Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient Signature _____

Score _____/50

NECK DISABILITY INDEX

Revised Owestry

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

SECTION 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can not do any work at all.

SECTION 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 – Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Patient Signature _____

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Score _____/50